NSW Regional HEALTH PARTNERS
CENTRE FOR INNOVATION IN REGIONAL HEALTH

# NSW Regional Health Partners Submission to AMRAB

In September 2020, consistent with the Medical Research Future Fund Act 2015, the independent Australian Medical Research Advisory Board (AMRAB) conducted a consultation to develop the Medical Research Future Fund (MRFF) Australian Medical Research and Innovation Priorities for 2020-22.

NSW Regional Health Partners used the opportunity to advocate for rural and regional health priorities, and the details of the submission are provided below.

## Do the current Priorities remain relevant in the contemporary environment for continuation for a further 12 months?

The 2018-20 priorities remain highly relevant to improving health outcomes and improving patient and provider experiences. However, their current *operationalisatio*n does not adequately reflect the MRFF Funding Principles and needs new focus. These principles reference the need for diverse perspectives in review, interdisciplinary partnerships, agility and co-investment. The MRFF is taking two broad overall approaches, one focused on innovation and commercialisation (e.g. MTPConnect), and another that could be described as 'NHMRC with a twist'. In the case of the latter, funding vehicles, governance structures (e.g. Mission Advisory Boards) and assessment processes remain dominated by traditional excellence metrics (e.g. research team track record) and a biomedical focus. (It is laudable that assessment panels and criteria for some MRFF grants have recently been broadened, with great results).

Currently, between these two approaches, a very fertile field is being neglected - where Australia's health services are trying to improve care, but without the evidence they need. T3 and T4 research gaps (translation to practice and to community) can become non-existent, with research immediately entering practice, if those in charge of health system delivery are invested from research inception - via co-funding and co-design. Solutions are co-funding via partnership style grant schemes and expansion of the Rapid Applied Research Translation (RART) grants that have allowed the accredited Centres for Innovation in Regional Health (CIRHs) and Advanced Health Research Translation Centres (AHRTCs) to engage in co-design and clinician capacity building with their health partners. However, RART funding represents just 3.5% of MRFF expenditure.

## Should any of the Priorities be emphasised or de-emphasised for the next 12 month period? If yes, please indicate specific priorities and why?

The MRFF emphasis on vulnerable populations – ageing and aged care and Aboriginal and Torres Strait Islander health and on primary care is appropriate. However, greater emphasis is needed on:

### 1. Primary Care Research

Primary and community care, despite their importance to the health of Australians, is tragically devoid of research funding as a consequence of service delivery funding models and past NHMRC

decisions. A considerable effort is needed to build capacity in this sector (e.g. PhD scholarships, Fellowships, long term support of Practice-Based Research Networks). In fact, this area would be an excellent choice for a 10 year investment plan of the 'Mission' variety.

### 2. Ageing and Aged care

Ageing and aged care, together with end of life care, requires greater emphasis, particularly for rural and remote populations. For instance, specialist palliative care is not widely available outside capital and regional cities. Further translational research is required to trial alternative models of end of life care and facilitate peri-operative shared decision making for patients with complex co-morbidities.

### 3. Clinical Researcher Capacity

Currently, exaggerated focus on competition to foster 'excellence' results in minimal support for clinicians to identify and close gaps where existing research does not address clinical concerns or patient experience. More incentives and obligations are required to encourage research at all levels of the health system and across health professional curricula, and actions outside the MRFF should be undertaken to complement MRFF investment.

## Are there any unaddressed gaps in knowledge, capacity and effort across the healthcare continuum and research pipeline that would warrant changes to the Priorities? If yes, please explain how it should be addressed in the 2020-22 MRFF Priorities

### 1. Unaddressed gap: Regional and Rural Health

As they stand, the priorities do not address the considerable inequity in health outcomes in rural and regional populations and the services available to these populations. Prioritising rural health research, and translational rural health research in particular, will directly complement the existing priorities, and improve the lived experiences of rural Australians.

There is an overall lack of opportunity and incentive for health professionals to develop research skills and apply these skills on the job. This applies to both hospital and community-based clinicians, but the gap is wider for general practitioners and especially for rural clinicians. This has a flow-on effect on health outcomes and patient experiences, but also on health providers' experiences and therefore the recruitment and retention of clinicians to rural areas. Dedicated and targeted funding to build rural "Clinical Researcher Capacity" is critical to this.

CIRHs are a new part of Australian "Translational Research Infrastructure". They have strong partnerships with universities, medical research institutions and health services. A long-term commitment to the funding and work of CIRHs (and to geographic coverage of regional and rural Australia) will increase the research skills of rural clinicians and support the delivery of research in situ, which will improve both regional and rural health outcomes.

### 2. Unaddressed gap: Evaluation

The inadequacy of clinicians' and decision makers' knowledge and understanding of evaluation and economic evaluation in particular is a major barrier to research translation. The result is considerable waste in the health system including the delivery of healthcare of unknown or negligible benefit. Comparing the value of different health interventions is an existing priority, but this may be more meaningful if reframed to include system support and education in evaluation and

health economics. Thus, research that explicitly builds capacity in this area ('human translational research infrastructure') is needed and will accelerate translation overall. The increased skills and knowledge need to be complemented by greater incentives and obligations for health services to incorporate evaluation, and therefore evidence, in service delivery and resourcing decisions.

Secondly, In the case of the entire MRFF research program, a greater focus on measuring impact and including sophisticated prospective estimation of the likelihood of research providing value for money would be advantageous (especially post COVID). There are two aspects to this, firstly ensuring that more agile and cheaper research approaches are incentivised (e.g. data re-use, pragmatic trials). Secondly this can help ensure that we invest in research that results in development of innovations that are likely to be affordable and thus widely implemented (and that do not add to health inequity).

## Do you have any additional comments in regards to the Priorities for 2020-2022?

Overall, translational health research remains undervalued and underfunded in Australia. While research translation attracted 30% of MRFF funds in 2020/21, only 2.9% of this allocation went to primary health care research and 11.7% to rapid applied research translation. Greater investment in translational research will help realise the potential of existing research by sharing findings more quickly and effectively thereby reducing wasteful interventions and ensuring best evidence-based health care for all Australians.

For most MRFF grant applications, the submitted proposed translational plan is merely a hopeful vision! Without routine structural links into system design (partnerships with service funders) and strong health economic analyses, the processes of research translation will remain largely random. Therefore, current gaps between research finding and practice will remain *and* new gaps will continually be created.

Building research skills in clinicians, and researchers' understanding of health care, will assist collaboration and problem-based research. Incentivising state governments to work with the translational research centres would support this, as would a stronger requirement for research training to be a key performance indicator for health services, and a core component of all primary health degrees. This also requires increasing the number of AHTRCs and CIRHs and their reach – so every Australian health service and geographic area is able to benefit.